APPLE TREE
FINANCIAL NETWORK

8101 34TH AVE S, SUITE 380 ◣ BLOOMINGTON, MN 55425
PHONE: 952.853.1235 ◣ FAX: 952.853.0935
TOLL FREE: 877.853.1235
E-MAIL: info@appletreefn.com

**AGENT'S NAME:** _____

**AGENT'S PHONE:** _____ **AGENT'S FAX:** _____

| | |
|---|---|
| **CLIENT'S NAME** | **PLAN OF INSURANCE** |
| **D.O.B.** | **AMOUNT DESIRED** |
| **PLACE OF BIRTH** | **BENEFICIARY (Name & Relationship)** |
| **SOCIAL SECURITY NUMBER** | |
| **RESIDENT ADDRESS** | **HOW MUCH INSURANCE IN FORCE NOW?** |
| ☐ **MARRIED** ☐ **SINGLE** ☐ **DIVORCED** ☐ **WIDOWED**<br>☐ **MALE** ☐ **FEMALE** | **HEIGHT** _____ **FT.** _____ **IN.**<br>**WEIGHT** _____ **LBS.** |

**Has this case been submitted to other companies in the past six (6) months?** ☐ **YES** ☐ **NO**

***If yes, list companies, file numbers and dates submitted.***

## LIST ANY INSURANCE THAT WAS APPLIED FOR THAT WAS RATED OR DECLINED

| *NAME OF COMPANY* | *AMOUNT* | *YEAR* | *STD. PREMIUM* | *INSURED?* | *EXTRA PREMIUM* | *REASON Rated or Declined* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

| | *Name and Address* | *Reason* | *Date* |
|---|---|---|---|
| What physician did you last consult? (other than insurance exam) | | | |
| In what hospitals, clinics or sanitariums have you been treated? | | | |
| Who is your personal physician? | | | |
| When was your last consult? | | | |
| Have you ever used any form of tobacco? ☐ YES ☐ NO | *If yes, give forms and frequency:* | | |
| Has use been discontinued? ☐ YES ☐ NO | *If yes, please detail, date and reason:* | | |

---

***Notice to Proposed Insured – Part I***
***Notice of Insurance Information Practices – In the course of property underwriting and administering your insurance coverage, the listed insurance companies will rely primarily on information provided by you. The companies may also see information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report by contacting the consumer reporting agency as explained in the Federal Fair Credit Reporting Act Notice.***

In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and see copies of your personal information which appears in the insurance companies' files, including information contained in investigative consumer reports. You also have the right to correct information you believe to be inaccurate.

**CREDIT REPORTING ACT**
**P.O. Box 105, Essex Station, Boston, MA 02112, Phone: 617.426.3660**

The companies listed in this notice, or their reinsurer, may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

# HIPAA Compliant Authorization to Release Confidential Medical Information

**Records and information obtained will be disclosed to:** _____
Insurance Company

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

**I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:**

Medical Facility Name: _____

Address: _____

City/State/zip: _____

**To release any and all records and information regarding:**

Patient's Name: _____

Other Names Used: _____

Date of Birth: _____ Social Security Number: _____

Specifics to be released: _____

**To be released to and exchanged between the insurance company first named above, and:**

_____

_____

_____

**and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.**

I understand that when information is used or disclosed pursuant to this application, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting this in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

**SIGNATURE:** _____ **Date:** _____
(Patient, Guardian*, or Authorized Representative*)
*Please provide documents to prove authority to sign on behalf of the patient

**Abacus Settlements**
**American General Life Companies**
**American National**
**Assurity Life Insurance**
**Aviva Life & Annuity Company**
**Banner Life**
**Berkshire Settlements**
**Cincinnati Life**
**Coventry Financial**
**Fidelity Life Association**
**Genworth Life Insurance Company**
**Genworth Life & Annuity Insurance Company**
**Great West Growth**
**Habersham Funding**
**Independent Funding Group**
**ING**
**JG Wentworth**
**John Hancock**
**Liberty Life**
**Lincoln Benefit Life**
**Lincoln National Life**
**Maple Life Financial**
**MetLife Investors**
**Neuma, Inc.**
**Peachtree Life Settlements**
**Principal Life**
**Prudential**
**RBC Insurance**
**Reliastar**
**Security Life of Denver**
**Transamerica**
**Union Central / Ameritas**
**VESPERS Financial Group**
**Welcome Funds**
**West Coast Life**

## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that the life insurance companies named above, their reinsurers, any insurance support organizations, and the representatives of these companies may need to collect information on me in regard to proposed life insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish to the insurance companies named above the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to evaluate my insurance application to Appletree Financial Network, Inc. I authorize my current insurance company to furnish Appletree Financial Network, Inc. and/or its authorized representatives with any information and forms in connection with my policy including any conversions or replacements thereof.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit or other personal traits.

The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance companies named above, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I understand that I may request to receive a copy of this Authorization. I acknowledge receipt of the Notice to Proposed Insured.

**Signed at _____ this _____ day of _____, 20_____.**

**Print Name** _____

**Signature** _____

***AGENT INSTRUCTIONS: The notification appearing below must be given to the proposed insured before or at the time of signature.***
*……*

**Notice To Proposed Insured**
Federal Fair Credit Reporting Act Notice
In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial resources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the life insurance companies listed in this notice within a reasonable time after receipt of this Notice, you will be informed whether or not any investigative consumer report was made. The consumer-reporting agency, upon request, will furnish information as to the nature and scope of this investigation. You have the right to inspect and receive a copy of any such report by contact in the consumer-driven agency.

MIB Disclosure Notice
Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurer may, however, make a brief report thereon to the Meidcal Information Bureau, Inc., a non-profit member organization of life insurance companies, which operates an informational exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the Federal Fair Credit Reporting Act.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LIFE INSURANCE COMPANIES AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO:

**APPLETREE FINANCIAL NETWORK, INC. 8101 34th AVE S, SUITE 380, BLOOMINGTON, MN 55425**

Print Form

# Instructions for Minnesota Standard Consent Form to Release Health Information

**Important: Please read all instructions and information before completing and signing the form.**

**An incomplete form may not be accepted. Please follow the directions carefully.** If you have any questions about the release of your health information or this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

---

***The following are instructions for each section. Please type or print as clearly and completely as possible.***

1| Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or patient identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2| If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3| In this section, state who is sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request more clear. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4| Indicate where you would like the requested health information sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5| Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information. This helps prevent others from changing your form.
EXAMPLE: _*jh*_ All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

**Important:** There are certain types of health information that require special consent by law.

**Chemical dependency program** information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the bottom of page 1.

**Psychotherapy notes** are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6| Health information includes both written and oral information. If you do not want to give permission for persons in section 3 to talk with persons in section 4 about your health information, you need to indicate that in this section.

7| Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8| This consent will expire one year from the date of your signature, unless you indicate an earlier date or event. Examples of an event are: "60 days after I leave the hospital," or "once the health information is sent."

9| Please sign and date this form. If you are a legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

MINNESOTA MDH DEPARTMENT of HEALTH

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

THE GREAT SEAL OF THE STATE OF MINNESOTA L'ETOILE DU NORD 1858

JAN2008

# Minnesota Standard Consent Form to Release Health Information



## 1 Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ /___ / _____ Previous name(s) _____
MM DD YYYY

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

Medical Record/patient ID number (optional) _____

## 2 Contact for information about how this form was filled out (optional) :

I give permission for the organization(s) listed in section 3 permission to talk to

First name _____ Last name _____ about how this form was completed,

this person can be reached at: Daytime phone _____ E-mail address (optional) _____

## 3 I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

## 4 I am requesting that health information be sent to:

Organization(s) name _____

**And/or** person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / _____ (optional)
MM DD YYYY

## 5 Information to be released

**IMPORTANT: indicate only the information that you are authorizing to be released.**

☐ Specific dates/years of treatment _____

☐ All health information *(see description in instructions for what is included)*

**OR** to only release specific portions of your health information, indicate the categories to be released:

| | | |
|---|---|---|
| ☐ History/Physical | ☐ Mental health | ☐ HIV/AIDS testing |
| ☐ Laboratory report | ☐ Discharge summary | ☐ Radiology report |
| ☐ Emergency room report | ☐ Progress notes | ☐ Radiology image(s) |
| ☐ Surgical report | ☐ Care plan | ☐ Photographs, video, digital or other images |
| ☐ Medications | ☐ Immunizations | ☐ Billing records |

☐ Other information or instructions _____

**The following information requires special consent by law.** Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(see definition in instructions)*

☐ Psychotherapy notes *(this consent cannot be combined with any other; see instructions)*

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

JAN2008

# Minnesota Standard Consent Form to Release Health Information

**Patient's name** _____ 

## 6 Health information includes written and oral information

By indicating any of the categories in section 5, you are giving permission for written information to be released **and** for a person in section 3 to talk to a person in section 4 about your health information.

If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your health information, indicate that here (check mark or initials) _____

## 7 Reason(s) for releasing information

- ☐ Patient's request
- ☐ Review patient's current care
- ☐ Treatment/continued care
- ☐ Payment
- ☐ Insurance application
- ☐ Legal
- ☐ Appeal denial of Social Security Disability income or benefits
- ☐ Marketing purposes (payment or compensation involved? ☐ NO ☐ YES, amount _____ )
- ☐ Other (please explain) _____

## 8

I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4 above.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3. If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party named in section 4 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

**This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:**

Date ___ / ___ / _____ Or specific event _____
MM DD YYYY

## 9

**Patient's signature** _____ Date ___ /___ /_____
MM DD YYYY

**Or** legally authorized representative's signature_____ Date ___ /___ /_____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.)_____

Print Form

This form was approved by the Commissioner of the Minnesota Department of Health on January 30, 2008.

# HIPAA Compliant Authorization to Release Confidential Medical Information

**Records and information obtained will be disclosed to:** _____
Insurance Company

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

**I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:**

Medical Facility Name: _____

Address: _____

City/State/zip: _____

**To release any and all records and information regarding:**

Patient's Name: _____

Other Names Used: _____

Date of Birth: _____ Social Security Number: _____

Specifics to be released: _____

**To be released to and exchanged between the insurance company first named above, and:**

_____

_____

_____

**and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.**

I understand that when information is used or disclosed pursuant to this application, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting this in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

**SIGNATURE:** _____ **Date:** _____
(Patient, Guardian*, or Authorized Representative*)
*Please provide documents to prove authority to sign on behalf of the patient

**Abacus Settlements**
**Allianz Life & Annuity Co.**
**American General Life Companies**
**American National**
**Assurity Life Insurance**
**Aviva Life & Annuity Company**
**Banner Life**
**Berkshire Settlements**
**Cincinnati Life**
**Coventry Financial**
**Fidelity Life Association**
**Genworth Life Insurance Company**
**Genworth Life & Annuity Insurance Company**
**Genworth Life & Annuity Insurance Company**
**Great West Growth**
**Habersham Funding**
**Independent Funding Group**
**ING**
**JG Wentworth**
**John Hancock**
**Liberty Life**
**Lincoln Benefit Life**
**Lincoln National Life**
**Maple Life Financial**
**MetLife Investors**
**Neuma, Inc.**
**Peachtree Life Settlements**
**Principal Life**
**Prudential**
**RBC Insurance**
**Reliastar**
**Security Life of Denver**
**Transamerica**
**Union Central / Ameritas**
**VESPERS Financial Group**
**Welcome Funds**
**West Coast Life**

## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that the life insurance companies named above, their reinsurers, any insurance support organizations, and the representatives of these companies may need to collect information on me in regard to proposed life insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish to the insurance companies named above the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to evaluate my insurance application to Appletree Financial Network, Inc. I authorize my current insurance company to furnish Appletree Financial Network, Inc. and/or its authorized representatives with any information and forms in connection with my policy including any conversions or replacements thereof.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit or other personal traits.

The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance companies named above, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I understand that I may request to receive a copy of this Authorization. I acknowledge receipt of the Notice to Proposed Insured.

**Signed at _____this_____day of _____, 20_____.**

**Print Name** _____

**Signature** _____

***AGENT INSTRUCTIONS: The notification appearing below must be given to the proposed insured before or at the time of signature.***

**Notice To Proposed Insured**

Federal Fair Credit Reporting Act Notice

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial resources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the life insurance companies listed in this notice within a reasonable time after receipt of this Notice, you will be informed whether or not any investigative consumer report was made. The consumer-reporting agency, upon request, will furnish information as to the nature and scope of this investigation. You have the right to inspect and receive a copy of any such report by contact in the consumer-driven agency.

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurer may, however, make a brief report thereon to the Meidcal Information Bureau, Inc., a non-profit member organization of life insurance companies, which operates an informational exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the Federal Fair Credit Reporting Act.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LIFE INSURANCE COMPANIES AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO: